STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	R-C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA NURSING CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE

{F 000} INITIAL COMMENTS

An unannounced Medicare/Medicaid revisit survey to the standard survey ending 2/28/17, was conducted on 4/4/17 through 4/5/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B.

The census in this 100 certified bed facility was 88 at the time of the survey. The survey sample consisted of 11 current record reviews (Resident #101-#111).

{F 329} SS=D 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

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1. The nurse responsible for failing to use non-pharmalogical measures before administering Xanax to Resident #102 is part time and failed to attend the inservice given regarding use of non-pharmalogical measures. The nurse received 1-1 instructions from the DON regarding the importance of using and documenting non-pharmalogical measures. 04/07/17

2. A 100% audit of PRN medications and chart documentation from 2/28/17 to 04/17/17 was completed by the ADON and Unit Managers. 04/18/17

3. The nursing staff received repeat education on the importance of using and documenting non-pharmalogical measures prior to giving any PRN medication with emphasis on psychotropic medications. 04/12/17

4. Unit Managers continue to report to the risk management committee on PRN medication usage. The QA nurse will review monthly compliance and report to the QA committee quarterly. 4/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Virginia M. Snead | TITLE: Administrator | (X6) DATE: 4/19/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 329}	Continued From page 1	{F 329}		

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to ensure the medication regimen for one of 11 residents in the survey sample, (Resident #102), was free from unnecessary medications.

Facility staff failed to attempt non-pharmacological interventions prior to the administration of prn (as needed) anti-anxiety medication for Resident #102.

The findings include;

Resident #102 was admitted to the facility on 09/21/15 and readmitted on 12/01/16 with diagnoses that included but were not limited to major depressive disorder, systemic inflammation response syndrome, hypothyroidism, high blood pressure, high cholesterol, and chest pain.
Resident #102's most recent MDS (minimum

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{F 329}	Continued From page 2	{F 329}		

data set) was a quarterly assessment with an ARD (assessment reference date) of 03/17/17. Resident #102 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #102 was coded as needing supervision only with most ADLS (Activities of Daily Living) including transfers, ambulation, locomotion, eating, and hygiene; and extensive assistance with bathing.

Review of Resident #102's POS (Physician Order Sheet) dated 02/24/2017, documented the following order: "Xanax [1] (alprazolam) -Schedule IV tablet; 0.25 mg (milligrams): ONE TAB (tablet); oral Special Instructions: PRN for Anxiety. Twice a day -PRN (as needed)." This order was initiated on 07/11/16.

Review of Resident #102's April 2017 (Medication Administration Record) revealed that Resident #102 received Xanax prn on 04/03/17 at 7:16 p.m. The following was documented under "Reasons/Comments: 04/03/17 at 7:16 PM, PRN Reason: Behavior Issue. Comment: Anxiety."

Documentation of non-pharmacological interventions attempted prior to the administration of PRN Xanax could not be found in the clinical record.

On 4/5/17 at 11:40 a.m., an interview was attempted with the nurse who administered the Xanax to Resident #102 via telephone. This nurse could not be reached.

On 4/5/17 at 11:45 a.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked about the process followed prior to

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{F 329}	Continued From page 3	{F 329}		

administering prn anti-anxiety medication, LPN #2 stated that she would try to redirect the resident, provide one to one supervision, and any other non-pharmacological interventions. LPN #2 stated that some residents will refuse non-pharmacological interventions and she will document refusals in the nursing notes. LPN #2 stated that she also documents non-pharmacological interventions that were attempted prior to the administration of anti-anxiety medication. LPN #2 stated that this information would be documented either on the MAR or in a nursing note.

On 4/5/17 at 11:51 a.m., an interview was conducted with LPN #1, the unit manager. When asked about the process followed prior to administering prn anti-anxiety medications, LPN #1 stated that she would attempt non-pharmacological interventions prior to administering prn anti-anxiety medications. LPN #1 stated that interventions attempted should be documented on the E-MAR (electronic administration record) or in a nursing note. LPN #1 stated interventions attempted should always be documented. LPN #1 confirmed that there was no documentation that Resident #102 was offered non-pharmacological interventions on 4/3/17 prior to receiving Xanax.

On 4/5/17 at 12:21 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated, "(Name of nurse who administered Xanax) is usually very thorough, but if it wasn't documented, than it wasn't done." ASM #2 attempted to reach the nurse who administered the Xanax on 4/3/17, and left a message for a call back to the facility.

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{F 329}	Continued From page 4 On 4/5/17 at 1:35 p.m., an interview was conducted with Resident #102. When asked if staff will try other things when she is feeling anxious to ease her anxiety before giving her medication, Resident #102 stated, "No." On 4/5/17 at 1:35 p.m., further interview was conducted with ASM #2. She stated that she could not get in touch with the nurse who administered the Xanax. ASM #2 was made aware of the above concerns. Facility policy titled, "Psychotropic drugs" documents in part, the following: "Procedure...a. The resident's chart must contain an appropriate diagnosis for use and the diagnosis should also be entered onto the Physician's Order Sheet and on the Medication Administration Record. b. Non-Drug interventions have been attempted and documented as ineffective..." No further information was presented prior to exit. [1] Xanax- Used to relieve symptoms of anxiety and panic disorder in some patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details	{F 329}		
{F 514} SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	{F 514}	1. Admissions note for Resident #105 was corrected by Admissions again with particular note to date, time, and mode of transportation. 4/17/17 2. 100% audit of all admissions since 2/28/17 to ensure all information is correct with particular attention to time of arrival and mode of transportation 04/05/17	

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{F 514}	Continued From page 5 are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized {5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for 1 of 11 residents in the survey sample; Resident #105. For Resident #105, the facility documented the resident was readmitted to the facility approximately 5.25 hours before the resident was	{F 514}	3. Administrator has inserviced Admissions on proper documentation, accuracy, and reviewed list of required information needed in admission note. Also reviewed difference in military time and eastern standard time. 4. Admissions will give copy of admissions note to Administrator after every admission to be reviewed for accuracy. Admissions will report to weekly risk managment meeting regarding admissions for previous week and report any discrepencies noted.	04/5/17 04/5/17

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{F 514}	Continued From page 6	{F 514}		

actually readmitted; and incorrectly documented the details of the resident's readmission in the same note.

The findings include:

Resident #105 was admitted to the facility on 5/2/13 and readmitted on 4/3/17 after a brief hospitalization, with the diagnoses of but not limited to altered mental status, Parkinson's disease, osteoporosis, rectal prolapse, dementia with behaviors, vertebral fracture, high blood pressure, insomnia and psychosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/6/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for bathing; extensive care for hygiene, transfers and dressing; supervision for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the following notes:

A note dated 4/3/17 at 1:11 p.m., by OSM #1 (Other Staff Member #1, the admission coordinator) that documented, "Resident returned to (facility and room number) via wheelchair van to receive long term care services. Resident is alert and oriented with confusion. Resident is sweet, opinionated and friendly. She enjoys socializing, being helpful, various activities and family. Family is involved and supportive and visits. Resident travels through facility via wheelchair and without assistance. Readmit for

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{F 514}	Continued From page 7	{F 514}		

was signed and all previous admission forms remain in place. Advance directives were discussed and code status remains DNR (do not necessitate)."

A nurse's note dated 4/4/17 at 12:03 a.m., documented, "Resident readmitted this shift at 1830 (6:30 p.m.). Arrived via stretcher by 2 EMS (emergency medical services staff)...."

A review of the resident's Face Sheet documented, "Admit date 4/3/17 06:30 PM (latest return)"

On 4/4/17 at approximately 4:00 p.m., the Administrator and Director of Nursing (ASM #1 and #2 - Administrative Staff Member) were made aware of the findings.

On 4/5/17 at approximately 8:30 a.m., an interview was conducted with OSM #1. She stated that the documentation of the resident having returned to the facility when she had not was an error. She stated that she was multi-tasking as she was the only admissions person in that day, and had a new admission coming and this resident's readmission she was anticipating, and in the midst of that, documented for the wrong resident. She verified the information she documented regarding the resident's method of arrival was also inaccurate. The remainder of the details of the note, she stated, were accurate to this resident as she was familiar with this resident. However she stated she should not have documented on the resident until the resident had actually returned to the facility.

An "edited" note was provided, and OSM #1

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{F 514}	Continued From page 8	{F 514}		

stated on 4/5/17 at approximately 8:30 a.m., that after being made aware of the error, she attempted to correct the error. However, the edited note was identified as a "Readmit and quarterly note" rather than just a readmission note; contained additional details that related to the quarterly assessment that were not part of the original readmission note; and documented the resident returned to the facility at 16:30 (4:30 p.m.) which was still inaccurate.

A policy was requested and on 4/5/17 at approximately 12:00 p.m., ASM #5 (the former DON, facility consultant) stated there was no policy on this matter.

No further information was provided by the end of the survey.

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COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

April 11, 2017

Ms. Virginia Snead, Administrator
Amelia Nursing Center
8830 Virginia Street
Amelia, VA 23002

RE: Amelia Nursing Center
Provider Number 495358

Dear Ms. Snead:

Based on deficiencies cited during the survey ending February 28, 2017, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On April 5, 2017, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The April 5, 2017, revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of D), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Officer's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are